(3) The premium for the policy shall be paid either from the creditor's funds, or from charges collected from the insured debtors, or from both.

(4) Except as provided in Paragraph (5), a policy on which no part of the premium is to be derived from funds contributed by insured debtors specifically for their insurance must insure all eligible debtors.

(5) An insurer may exclude any debtors as to whom evidence of individual insurability is not satisfactory to the insurer.

(6) The total amount of insurance payable with respect to an indebtedness shall not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments that are delinquent on the date the debtor becomes disabled as defined in the policy.

(7) The insurance may be payable to the creditor or any successor to the right, title and i

Drafting Note: Under HIPAA, insurers that issue or offer to issue certain policies of health insurance coverage in the group market may not exclude or limit eligibility for coverage to individuals or their dependents based on a health-status related factor. A health status related factor, as defined under HIPAA, includes evidence of individual insurability. Section 9 of this Act provides authority for the commissioner to adopt regulations related to enrollment and eligibility for coverage consistent with HIPAA for those groups and policies subject to HIPAA requirements.

D. A policy issued to a trust, or to the trustees of a fund, established by two (2) or more employers and maintained, directly or indirectly, by those participating employers, or by one or more labor unions of similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, which trust or trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or organizations for the benefit of persons other than the employers or the unions or organizations, subject to the following requirements:

(1) (a) The persons eligible for coverage shall be all of the employees of the employers or all of the members of the unions or organizations, or all of any class or classes thereof.

(b) The policy may define "employee" to include:

(i) The employees of one or more subsidiary corporations;

(ii) The employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships if the business of the employer and of the affiliated corporations, proprietorships or partnerships is under common control;

(iii) Retired employees, former employees and directors of a corporate employer; and

(iv) The trustees or their employees, or both, if their duties are principally connected with the trusteeship.

(2) The premium for the policy shall be paid from funds contributed by the employer or employers of the insured persons, or by the union or unions or similar employee organizations, or by both, or from funds contributed by the insured persons or from both the insured persons and the employers or unions or similar employee organizations.

(3) Except as provided in Paragraph (4), a policy on which no part of the premium is to be derived from funds contributed by the insured persons specifically for their insurance must insure all eligible persons, except those who reject coverage in writing.

(4) An insurer may exclude or limit the coverage under the policy on any person as to whom evidence of individual insurability is not satisfactory to the insurer unless otherwise

E. (1) A policy issued to an association or to a trust or to the trustees of a fund established by an association or associations otherwise eligible for issuance of a policy under this subsection and maintained, directly or indirectly, by the association or associations for the benefit of members of one or more associations.

(2) (a) An association shall not be controlled by an insurer as evidenced by the operation of the association

(b) The following factors may be used as evidence to determine whether an association is an insurer-operated association; however, the presence of these factors shall not serve to limit or be dispositive of such a determination:

(i) Common board members, officers, executives or employees;

(ii) Common ownership of the insurer and the association or other eligible group; or

(iii) Common use of the same office space or equipment utilized by the insurer to transact insurance.

(3) An association may use the solicitation of insurance as one of its methods to obtain new members.

(4) The association or associations shall:

(a) Have at the outset a minimum of 100 persons;

(b) Have a shared or common purpose that is not primarily a business customer relationship;

(c) Have been organized and maintained in good faith primarily for purposes other than that of obtaining insurance;

(d) Have been in active existence for at least one year; and

(e) Have a consn (n)-024 Td [(-2.4 (t)s)-3.4 (i)-1.5 (n)-6.8.1 (n)2.4 (s sh)2.4 (a.1 (8.2 ( )]T

B. For any such coverage that is being offered in this state by an insurer under a policy issued in another state, the commissioner in this state or the state in which the policy is issued, having requirements substantially similar to those contained in Subsection A, must make a determination that the requirements of Subsection A have been met.

Drafting Note: Alternative language to Subsection B:

Alternative 1 This alternative consists of Subsection B above and Subsection C below.

B. (1) The insurer shall file with the commissioner for information purposes:

(a) A copy of the group master contract;

(b) A copy of the statute of the state where the policy is issued, authorizing the issuance of the policy under the same or similar statute;

(c) Evidence of approval in the state where the policy is issued; and

(d) Copies of all supportive material used by the insurer to secure approval of the policy in that state including the documentation in Subsection A.

(2) The commissioner, at any time subsequent to receipt of the information required under Paragraph (1), after finding that the requirements of Subsection A have not been met, may order the insurer to stop marketing the coverage in this state.

Alternative 2. Under this alternative the language in this Subsection B below may be used as a substitute for the language in Subsection B above.

B. (1) For any such coverage that is being offered in this state by an insurer under a policy issued in another state, the commissioner must make a determination that the requirements of Subsection A have been met.

(2) The insurer shall file with the commissioner:

(a) A copy of the group master contract;

(b) A copy of the statute of the state where the policy is issued, authorizing the issuance of A8 (t)-4.8 g6 (i)-1. (c)1.2 5 (s)-3.p0.5 (t)1.m.-2.9 (l)-tupyoryo bein(i) (s)-3.4

Drafting Note: States should adopt Subsections C and D below regardless of which alternative a state chooses to adopt for Subsection B above.

C. The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both.

D. An insurer may exclude or limit the coverage under the policy on any person as to whom evidence of individual insurability is not satisfactory to the insurer unless otherwise prohibited by any other applicable law or regulations adopted by the commissioner.

Drafting Error

the person during the twenty-four (24) months prior to the effective date of the person's coverage. In no event shall the exclusion or limitation apply to a disability commencing after the end of the two-year period starting on the effective date of the person's coverage.

(2) A policy that is subject to the preexisting condition exclusion requirements in Section 2701 of the Public Health Service Act, as added by Pub. L. No. 111-148, shall have a provision specifying any preexisting condition exclusions or limitations consistent with those requirements except as otherwise provided by state law.

Drafting Note: